Top-down (System Focused) vs. Bottom-up (Patient Focused) Approaches in Mental Health Care

Today (August 22, 2013), I met with an intern to discuss one of her mentally unwell patients who attends an affiliate naturopathic clinic in a local hospital. The patient* is a 35-year-old male with a diagnosis of schizophrenia. He had his first psychotic episode (really, a mental breakdown) when he was in teachers college a decade earlier. He found it very difficult to manage school stress as well as feeling ostracized by his peers. Following the mental breakdown the patient had seven additional hospital admissions in the past 10 years, as well as a lengthy history of prescribed psychotropic medication. He is currently on five psychotropic medications (i.e., aripiprazole, clonazepam, clozapine, quetiapine fumarate, and zuclopenthixol), one for Parkinsonism (apo-benztropine), and two others to ensure bowel regularity (docusate sodium and lactulose).

The patient had a lot going for him prior to his mental breakdown. He was the first in his family to be born in Canada and university-educated. His parents immigrated to Canada from the Caribbean and worked very hard to provide their son with a better life than they had. The parents are bereft of hope since they have witnessed their only child deteriorate while under the care of the current mental health system. Now, he is clinically obese, sleeps most of the day, drools frequently, has short- and long-term memory problems, is not working, spends most of the day inside and by himself, and is essentially non-functional. The patient's psychiatrist is considering an increase in aripiprazole since the patient still hears voices. The patient is also part of assertive community treatment (ACT) and has a team that meets with him regularly, but does little more than ensure psychotropic medication compliance.

This case is an unfortunate and all-too-common example of the consequences of our prevailing top-down system of mental health care. My usage of "top-down" denotes a mental health care system that takes its orders from the treating psychiatrist, which focuses on a medication-only paradigm of care, whereby all further patient care is directed toward psychotropic medication compliance by means of authority and social control. The current mental health system (at least in Ontario, Canada) does little to help patients live more fulfilling and better lives.

The prevailing system of mental health care falsely advertises that psychotropic drugs are "disease-modifying" agents capable of reversing the manifestations of mental "disease." Thus, psychotropic medications are promoted and prescribed since a patient's mental disease can be ameliorated or controlled with effective treatment. This "medication-only" paradigm has clearly operated in this patient's care, as his treatments for the past 10 years have focussed primarily on finding the correct combination of psychotropic medication.

Under this framework, systems are also put in place (e.g., ACT teams, community treatment orders, and substitute decision makers) to forcibly ensure (whether overtly and/or covertly) that a patient is maintained on psychotropic medication since only psychotropic medication and psychiatric treatment in general can restore a patient's abnormal mental state to normal. All the systems within the top-down hierarchy ensure medication compliance, even when patients are funneled into psychoeducation, day programs, or other activities and social supports. All of them champion the idea that the only way to normalize mental distress is by being consistent with psychotropic medication.

Above all, being a patient within this "top-down" framework means that you must become a recipient of the care afforded to you, since this is the only option that can return you to a normal level of functionality. As many of us know, this framework does little to improve functionality. In fact, if we look at this patient we can objectively see that he is brain damaged from the psychotropic medication, that his quality of life is abysmal, and that his lifespan has likely been reduced by some 10-25 years. I

**Identifying information has been altered to protect the confidentiality of this patient.*

do wonder how this patient might have turned out if he was given good empathic care when he had his initial mental breakdown. If he had been offered psychotherapy, orthomolecular medicine, and tools to build self-confidence, what might have been the outcome? Would he have had such a chronic and debilitating course? I doubt it, but we will never know.

For these and many other reasons, we as clinicians need to create a new system for our patients, where we serve as the coach or guide. I call this system "bottom-up", because it supports the patient by providing resources that are individualized, life affirming, and patient directed. Within this bottom-up framework psychotropic medication might be an option, but it would have to be presented with proper and valid consent and the patient would be given the freedom to refuse the prescription without any coercion or force. It relies on the collaboration of patient and clinician to come up with a viable strategy of recovery. This framework would also guide patients to many available resources (e.g., 12-step programs, mindfulness-based training, psychotherapy, exercise, and orthomolecular medicine) outside of the dominant mental health system since they serve to strengthen the patient's capacity to emotionally (i.e., affectively) regulate without compromising individual choice. The other tremendous benefit of this bottom-up approach is that it does not operate by coercing or oppressing the patient into a single paradigm of care, and thus does not infringe upon patients' civil liberties. (**Table 1,** below)

In this issue, I have written an extensive article on the points made in this editorial. I used to believe that the most important part of treatment was the orthomolecular medicines I prescribed. Over the past 15 years my views have considerably diverged from the purely "biochemical." I now see that the most important way for patients to recover is to encourage their self and interpersonal development through the use of numerous resources, for which the provision of orthomolecular medicine is part of a broader plan of coordinated mental healthcare instead of being the primary form of mental healthcare offered. I encourage all members of our community to send correspondence on their thoughts pertaining to this editorial and my article.

Jonathan E. Prousky, ND, MSc
Editor

Table 1. Central Differences Between "Top-down" and "Bottom-up" Mental Healthcare

Top Down	Bottom Up
The psychiatrist (or other medical professionals) forces (either covertly and/or overtly) psychotropic treatment.	Patient (with clinician as the guide or coach) determines treatment direction.
Patient told that this is the only method of treatment and that no other viable options exist.	Patient educated about numerous treatment options without force or coercion.
Mental health services primarily enforce medication compliance and undermine a patient's individual choice or preferences for care.	Patient engages with resources outside of the dominant mental health system which respect a patient's individual freedoms and civil liberties.